Environment

Key points

- The quality of inpatient environments continues to vary and we have seen examples of how ageing and poorly designed facilities affected patients' care.
- Being able to go outside brings therapeutic benefits for patients, but outdoor access varied across services. Gardens were usually well maintained, and in some services, patients were encouraged to grow plants and vegetables. However, we also found examples of unwelcoming gardens and at some services, patients' access to outdoor spaces was limited.

The Mental Health Act (MHA) Code of Practice sets out that "patients should be offered treatment and care in environments that are safe for them, staff and any visitors, and are supportive and therapeutic."

However, in our 2023/24 State of Care report, we highlighted how a lack of resources, ageing mental health estates and poorly-designed facilities can lead to issues around privacy and dignity for patients, as well as compromise the safety of both patients and staff. Through our MHA monitoring visits, we found that the quality of inpatient environments continues to vary. We remain concerned about the impact of poor quality environments on patients.

Ward environments

While we visited many wards that were suitable for patients' needs, we continue to see how issues with ward environments can affect people's care. As we reported last year, in some cases, these issues can lead to blanket restrictions.

We found issues in some older wards owing to the design and layout creating blind spots and ligature risks. To overcome these issues, some services used observation mirrors to cover blind spots.

As we discuss in the Inequalities section of this report, not all wards were accessible for patients with limited mobility. While a few wards had been adapted to meet the specific needs of individual patients, others had several staircases and out of reach call buttons, which made them unsuitable for wheelchair users.

Patients have a right to a suitable standard of environment, which is emphasised in respect of detained patients under the Standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. We expect inpatient environments to be well-decorated, welcoming, light, airy, clean, and homely, and many meet these expectations to some degree. However, in our 2023/24 State of Care report, we raised concerns about the environment of some mental health wards. These concerns were echoed on some monitoring visits. Where we found issues with unwelcoming environments, we were concerned about the effect on patients' dignity and safety:

> "During our tour of the ward, in one pod's lounge, we noticed that 4 glass panels in the door leading to the courtyard and a window had been damaged. A safety film had been placed over the damaged glass. We also noticed that one window, opposite the patient's bedroom, had been boarded up. The charge nurse informed us that the damage had occurred in February 2023. The clinical matron said the damaged windows were due to be replaced on 3 May 2023."

Most inpatient environments had single occupancy bedrooms, although not all dormitories have yet been converted or rebuilt. Nearly all bedrooms were ensuite, with an adjoining bathroom containing a shower, sink, and toilet. In a small number of cases, rooms without an ensuite and dormitory-style bedrooms shared single-sex bathrooms and toilets. Patients often personalised their rooms with decorations, bedding or photographs.

Security and privacy

The MHA Code of Practice states that hospitals should provide adequate storage in lockable facilities for patients' clothing and other possessions. Most wards now have single-occupancy bedrooms that contain a lockable storage space for patients to store valuable and personal items. A few wards have lockers outside of patients' bedrooms. Where services did not offer this facility, many patients always kept their valuable items with them.

> "There was no lockable storage for patients in their bedroom areas. Patients told us they kept valuable items on their person. None of the patients reported items going missing, however most patients were in shared dormitories and felt having a space to lock items away would be helpful."

Patients often controlled the locking and unlocking of their bedroom door. They were issued with either a wristband, key card, key fob, or key on admission to the ward. These gave patients control over entry to and from their bedroom, while also keeping personal items safe.

However, we found other examples where patients were not able to lock their bedroom doors. In some cases, this was because the same key opened all doors and keys were therefore for staff only. In others, there were no individual risk assessments for keys. Some patients told us about other patients accessing their rooms and items going missing from their bedroom because doors remained unlocked. It is important that services respect patients' privacy, and the MHA Code of Practice outlines that this encompasses the protection of their private property. In other services where bedroom doors auto-lock on closing, we have seen examples of patients using towels to prop open doors, which can present a fire safety issue.

Many bedroom doors have viewing panels to enable staff observation without opening the door itself. Viewing panels mostly operated from inside patient bedrooms as well as outside, providing patients with privacy. In these cases, staff could override the closing of a blind when necessary. Patients in one ward could state their preference through a notice message on their bedroom door regarding how they wished to be observed. MHA reviewers found another inpatient service using an electronic light system installed outside of patient bedrooms.

> "Viewing panels were kept closed and only opened when completing observations. The ward operated an electronic light system outside each bedroom door, so that if a patient was using the bathroom, staff would know not to open the viewing panel at that time."

Some services use contactless monitoring systems that replace the need for physical observation through viewing panels or opening patients' bedroom doors. This includes those known as 'vision-based monitoring systems' (VBMS), which are a type of data-driven digital healthcare monitoring technology. VBMS uses an infrared sensitive camera to allow non-contact monitoring of people's vital health signs, with some models incorporating a regulated medical device.

Several campaign groups have raised concerns about the use of VBMS, arguing that this can create safeguarding issues, cause people undue emotional distress and exacerbate existing fears, leading to poor care outcomes.

Detention under the MHA provides authority for care and treatment that will, inevitably, be perceived as intrusive. Observation by staff, particularly during the night, is one of the more severe forms of such intrusion. But it is also a necessary aspect of safety on most wards and an expectation of nursing care.

Outdoor and kitchen access

Being able to go outside brings therapeutic benefits for patients, and the MHA Code of Practice is clear that patients should also be able to access secure outdoor areas and a range of activities of interest. Through our monitoring visits, we found nearly all services had outdoor spaces for patients, but access to these areas varied. Outdoor areas and gardens were usually well maintained, with adequate seating, decoration, and plants, shrubs, and flowers.

In some services, patients were supported to gain independence through therapeutic outdoor activities, including growing a range of plants, flowers and vegetables:

> "There is a large allotment attached to the hospital. The [occupational therapist] for the ward co-led on the management of this space with patients. One patient on the ward worked on the allotment daily and has been responsible for many of the new developments. The allotment had a large range of plants growing including flowers and vegetables. It also had a range of animals including rabbits, chickens, birds, and a chameleon. This space expanded the range of activities available to patients to develop their independence."

In contrast, we found a few examples of unwelcoming gardens, particularly in high security settings. While these services have high perimeter fencing for safety, we also found insufficient seating for patients to sit outside and unwelcoming courtyards.

> "Patients had supervised access to fresh air in the 2 courtyards, but these were rather bleak and unwelcoming areas."

Access to outdoor and garden environments varied between inpatient services. Some inpatient services were found to have direct access to outdoor and garden environments, allowing patients to freely access these spaces at any time. At other services, outdoor space was limited or not provided:

> "The ward was located on the first floor and did not have a garden. Detained patients who did not have authorised section 17 leave had no access to an outside space and fresh air."

At another service, doors to outdoors and gardens were frequently locked, requiring staff to open them. Some services restricted access owing to historical safety concerns such as ligature risks and blind spots. At one service where this was the case, we recommended these risks be addressed to enable patients to go outside safely. We also visited a service where staff did not know if outdoor access should be restricted.

> "Staff appeared confused about the access patients had to the ward garden. They were unsure whether the garden door should be locked or not. Patients were unsure whether access was restricted or unrestricted."

Limited access to outdoor spaces was also raised as an issue by members of our Service User Reference Panel. Many panel members reported having no or limited access to outside space during their detention. One person spoke about not being allowed to use outside space on wet days, which upset them as they found being outside in the rain very calming.

The way patients spoke about the quality of food and drink, and access to it, was also mixed. At one service, many patients enjoyed the food provided and praised the level of choice and quality. At another, feedback from patients had driven improvements.

> "Patients all commented on the food, with views ranging from "ok" to "pretty good" and "very good." One patient said that there had recently been some negative feedback about the food in the ward community meeting, but since then, the food quality had improved, with 2 or 3 choices of meals available at each meal."

However, several patients told us about limited choice and repetitive meals, which left them feeling hungry. Some patients also reported a lack of hot meals and limited vegetarian options, while others noted ordering takeaway meals because they felt the food provided was bland. Healthy eating is often raised as a problem in inpatient units. It is vital that services offer a range of balanced, appetising meals, not only to promote a healthy diet but also to ensure people who are detained are treated respectfully and offered choice.

Access to food and drink also varied. Services need to balance protecting people's safety with promoting autonomy, and this variation in access to food and drink partly reflects differences in the needs and acuity of patients across services. Access to hot water must be risk assessed. Where these risk assessments demonstrate access to hot water must be limited, we expect services to ensure they follow the least restrictive approach and regularly review this so that the restrictions remain appropriate for the patient group.

Most services enabled patients to access food and drink independently, with people able to make their own hot and cold drinks throughout the day. Some inpatient environments also encouraged patients to cook for themselves, developing independent living skills in the process. Patients reported how cooking for themselves gave them a sense of pride.

> "The unit was recovery-orientated. One patient said, "The staff encourage people to be independent here." Patients assisted staff with shopping for, and the preparation of, communal meals. Patients told us proudly how they had learned to cook meals for everyone."

However, on some visits we found kitchens were not open to patients and patients had to ask staff for access:

> "The kitchenette was locked, with patients needing to ask to be able to get their own food from the cupboard or ask staff to prepare them a hot drink. The kitchenette had staff tea and coffee making facilities and storage for staff food, which gave the room the feel of being a staff resource rather than a clinical area."

Restrictive practices

In recent years' Monitoring the Mental Health Act reports, we have highlighted the progress made by some services in reducing unnecessary restrictive practices and creating therapeutic environments for patients. While we continue to find examples of providers reviewing restrictions to ensure they remain necessary for patients' safety, we remain concerned about the volume of instances where restrictive practices are used.

Mental health inpatient settings report occurrences of restrictive practice through the Mental Health Services Data Set (MHSDS). The level of reporting has increased in inpatient settings, which could reflect better reporting practices across providers. But at the same time, it could reflect that more people are being restrained and more types of restraint are being used. In 2023/24, on average, restrictive practices were reported over 14,200 times per month, a 4% increase from the previous year. Each reported incident could involve a range of restrictive interventions, and an individual might experience multiple interventions per month. On average, each month over 2,900 people were reported to be subject to restrictive interventions.

We recognise that restrictive practices are appropriate in limited, legally justified and ethically sound circumstances in line with people's human rights. But our expectations are clear: everyone working in health and care has a role to play in reducing the use of restrictive practices. Wherever restraint, seclusion or segregation is perceived to be the only safe option, providers must consider whether the services provided meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point.

Staff in many services were trained in methods of restraint. This included verbal de-escalation, physical restraint, chemical restraint and the prevention and management of aggression. Despite this, some staff members were observed using inappropriate language towards already distressed patients. This may infer a lack of staff training on how to interact with patients.

However, almost all highlighted shortcomings around training for new and permanent staff were already being corrected, with MHA reviewers assured that training was either completed, ongoing, or due to start soon.

Sometimes, issues with ward environments can increase the risk of blanket restrictions, meaning that access to areas is restricted for all patients, despite not all patients needing this level of restriction to keep them safe. In 2023/24, we found blanket restrictions were uncommon. Staff at most services reviewed restrictions regularly to ensure they remained proportionate.

In many cases, services were able to give us a clear rationale for the restrictions they impose. However, we continue to find examples of unnecessary restrictions and measures that did not support patients to be independent, such as locking doors to certain rooms:

> "At the time of our visit the doors to the sensory room, the therapy kitchen, the laundry room and the garden were all locked and patients could only access these areas under staff supervision. The rationale for these blanket restrictions was not recorded on a restrictions register."

The MHA Code of Practice has numerous requirements for seclusion rooms or areas, including:

- allowing for communication with the patient when the patient is in the room and the door is locked, for example, through an intercom
- having limited furnishing, which should include a bed, pillow, mattress and blanket or covering
- having no apparent safety hazards
- having no blind spots
- always having a clock visible to the patient within the room
- providing access to toilet and washing facilities.

Most seclusion rooms within inpatient environments met the MHA Code of Practice guidelines. We sometimes see rooms where furnishings such as the bed have been removed on grounds of safety, leaving just a mattress. Such interventions need to be carefully considered against individual risks, with suitable patient support, and should not become normalised. Some seclusion rooms also needed repair and cleaning. For example, we found instances where rooms had doors that couldn't be locked, hazardous screws not flush with the wall, broken locks and scratched windows, which made observations difficult.

On some visits, services told us they rarely use seclusion as an intervention and one ward won a trust 'Gold Ward' rating for not using seclusion for 2 years and having no instances of restrictive interventions in 2 months.

It was promising to find staff using a range of strategies, including verbal de-escalation and staff support to reduce the need for restrictive interventions.

> "Each patient had an individualised de-escalation 'grab bag' which the patient had been involved in creating. The bag included sweets, fidgets and other items that were helpful in calming the patient if they found their levels of agitation or anxiety were increasing."

However, some staff lacked training or space to safely restrain patients on the ward. In these environments, patients were transferred off-ward to more restrictive settings. Patients would be returned to the inpatient service when a bed was available.

> "We were informed that staff were not trained in using restraint and there was no space to do so safely. If patients were to become acutely unwell and physically aggressive, they would be transferred to other wards, such as [ward], a more restrictive rehabilitative setting, an acute ward, or psychiatric intensive care ward. Such transfers could be temporary, pending a return to [ward] when a bed was available."

Single-sex accommodation

In our 2023/24 State of Care report, we highlighted a concerning rise in the number of mixed sex accommodation breaches, which have safety implications for patients. People affected by mental ill health can sometimes act in disinhibited ways or may lack the mental capacity to make sound decisions about relationships. They may also have experienced abuse in the past, which might have contributed to their mental ill health, and could leave them at risk of being exploited by others.

The Mental Health Act Code of Practice highlights that women-only environments are important because of this increased risk of sexual and physical abuse, and previous trauma. It also states that consideration should be given to the needs of transgender patients.

Although inpatient environments were generally segregated by sex in line with the MHA Code of Practice, often with single-sex areas such as female-only lounges, some wards did not adhere to this requirement. Several services did not provide functioning and accessible women-only spaces. In some cases, single-sex spaces had issues with their locking systems or were used for other purposes. We also heard from some female patients who did not feel safe or supported when staying on mixed-sex wards.

> "When asked if they felt safe on this ward, 2 female patients said that they would have preferred to be on an all-female ward as they said they felt frightened sometimes when male patients were shouting on the ward."

At another service, technology was used to ensure sex segregation was maintained, with patients given electronic fobs that allowed them into the relevant corridor.

The NHS Constitution is clear that people admitted to hospital will not have to share sleeping accommodation with patients of the opposite sex. It has been mandatory for providers to report all mixed sex accommodation breaches since 2011. In 2023/24, in all care trusts, community trusts and mental health providers, there were 292 mixed-sex accommodation breaches, compared with 250 breaches in 2022/23.

Alongside this increase, research published in 2024 shows a concerning rise in the number of sexual safety incidents, including sexual assaults, in mental health wards. We have raised concerns about this for a number of years. In 2018, our Sexual safety on mental health wards report warned that people who use mental health inpatient services did not always feel that staff kept them safe from unwanted sexual behaviour. It also found ward environments did not always promote sexual safety for people using services.